USSR Letter

The phenomenon of the corridor patient

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By international standards, the Soviet Union today has an undoubtedly generous ratio of hospital beds to population. Over the years 1950-78, thanks to massive annual increases, the supply rose from 55.7 to 122.0 beds per 10 000 people. These figures for the whole Union conceal substantial spatial variations—as is true for many health care indicators—and the larger centres of population tend to have higher ratios. At the end of 1978 the city of Moscow had 137.7 beds for every 10 000 inhabitants.

Even in the capital, however, a shortage of vacant beds in the wards of many hospitals necessitates large-scale reliance on makeshift arrangements in corridors. Although this organisational problem cannot be measured from published data, its existence has been acknowledged recently not in oblique or coded references but in two undeniably frank articles published by *Literaturnaya Gazeta*.^{1 2}

The first article contains the text of an interview with a head doctor, who among other achievements has managed to return the corridors to their proper use. At this juncture, incidentally, it should be explained that the unit in question is a well-known centre of excellence bearing the title: Order of Lenin teaching hospital named after S P Botkin. In the opinion of its head doctor the problem represented by "corridor patients" was endogenous; he considered that it arose from organisational failures "as a result of which a patient remains too long under hospital care and at the same time does not receive what is essential." The absence of patients in his corridors was closely linked to striking improvements in two standard indices of efficiency—average duration of stay and bed turnover. (The latter represents the average number of patients treated per bed during one year, and in the Botkin hospital this index had risen from 14.5 to 16.4 over the five years 1975-9.)

Total Control

The independent variable in this exemplary state of affairs was an improved management system whose essential feature the head doctor described as follows: "we control everyone and we control everything." Among the specific features of this regimen is the arrangement whereby patients may be discharged on any day of the week—a flexibility that contrasts with the rigid practices encountered in many hospitals. No patient, however, may be discharged before time to free a bed for an emergency, since that is guarded against by a hierarchical check on case notes. These must be submitted to the departmental head, who will complete the discharge form only if he is satisfied that everything is in order.

Scrutiny of the case notes brings to light specific omissions

or mistakes but more generally enables the quality of care to be improved at the same time as eliminating inexcusable delays. To prove his point, the head doctor cites the example of patient R (whose case notes apparently lie to hand). She was seen at 1800, when croupous pneumonia was diagnosed. But clearly radiography was not done until 1955—which gives cause for a red mark on the record and will lead to a reprimand for the "guilty persons."

While everything that is necessary must be done for the patient, the corollary is that superfluous activities by the staff must be kept at an irreducible minimum. As the chief doctor expressed it: "We have not only defined the list of duties, the functions of each link in the chain, but have also assigned a time for the fulfilment of these functions, which seemed no less important." So, from 0830, when the working day begins, until 1300 all members of staff must keep to their remit, postponing until the afternoon such non-urgent items as attendance at meetings. This imposed structure, together with clear delegation of responsibility, has meant that the doctors have more time for treating patients and for considering developments likely to enhance still further the effectiveness and efficiency of the hospital. One product of their liberated creativity was a new specialised diagnostic department that has largely dispensed with the need for preliminary investigations at polyclinic level. Such investigations generally cause delays in treatment ("at times they drag on for weeks") but now at the Botkin hospital patients are admitted as soon as possible and subjected to two days of intensive tests in the diagnostic department, straight after which, if necessary, they are operated on. Thanks to the speedy identification of disease and to intensive treatment the hospital has succeeded in reducing average duration of stay. Unfortunately the head doctor gave figures for only one condition: over the years 1975-9 a sharp decline occurred in the stay for chronic appendicitis—from 18.5 to 11.6 days.

Is the emergency service to blame?

After publication of the interview with the head doctor at the Botkin, *Literaturnaya Gazeta* received many letters whose authors generally considered that improvements in hospital efficiency could not be relied on to empty the corridors. As an example, the editor cited the fatalistic view expressed by one nurse that, "the patient has always lain in the corridor and always will." Another nurse, who works in a Moscow neurological department, asked how they could avoid filling the corridors with beds when the patients kept on being brought to them by the emergency service.

Here it should be noted that the emergency service which operates in urban areas of the Soviet Union is broadly comparable with Britain's ambulance service, combined with an element of primary medical care provided by full-time staff. The salient role of the service in Moscow (with a population of roughly 8 million) can be gauged from the fact that over a period of four hours it takes to hospital roughly 800 people.

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That figure was among the information conveyed in the second article, which mainly consists of a commentary written by the head of the capital's emergency service, Dr N Kaverin.

His commentary on the letters opens with a rebuttal of one correspondent's charge that the emergency service tended to bypass the Botkin, transporting cases on to other "non-privileged" units. In fact, in the months of highest morbidity more than half of all patients at the Botkin are brought there by the service. Dr Kaverin then proceeds to identify several practices that exacerbate structural tensions between his staff and hospital personnel, who complain that "all would be fine and peaceful" but for the intrusion of emergency admissions.

Causes of tension

When summoned to an emergency by a "03" telephone call, the staff of his service have no choice but to take to hospital certain classes of patient without delay. Thus they have been deprived of discretion when severe stomach pain is reported. (For the readers of *Literaturka*, as the paper is affectionately known, Dr Kaverin explains that this could indicate a strangulated hernia, appendicitis, perforated ulcer of the stomach, or intestinal obstruction.) Another comparable regulation of the USSR Health Ministry requires the compulsory admittance to hospital of a patient suspected of "severe vascular disease." But although the "03 brigades" are conforming to unambiguous rules, they encounter complaints, if not resistance, from the receiving hospitals.

Some units (perhaps only the clinics of research institutes) have started to select and reject patients according to their special interests. Several have reached the point of complaining if they are brought a patient over a certain age—for instance, anyone aged over 60 suffering from a myocardial infarct.

As for neurological departments in the Moscow hospitals, only 14 out of 33 will accept patients at any time of day or night. Several refuse emergency admissions after 1500 and at the weekends. In seven large district hospitals there is no round-the-clock neurological service, which inevitably gives rise to severe pressure on other units in their vicinity.

Wasting bed days

Another obvious cause of overcrowding, declared Dr Kaverin, lay in lack of flexibility in discharge policies. (At the Botkin, as I pointed out earlier, this shortcoming has been rectified.) Dis-

charges are rarely arranged on Saturday or Sunday but the emergency service, which does not reduce the number of its brigades on these days, continues to bring in the patients. A similar instance of the inefficient use of scarce beds is provided by planned admissions to hospital on a Friday, although these patients cannot undergo investigation or receive treatment until after the weekend.

Another factor that has a far from trivial impact on overcrowding is the temporary closure of beds in connection with *remont*. That term has a broad connotation ranging over such items as repairs, servicing, redecorating, and rebuilding in many spheres of life; it is often associated with inconvenience and delays. According to data collected by the emergency service, the total volume of "overloading" (this probably means temporary beds in corridors) is equal to the total number of hospital beds out of commission at any one time due to *remont*. Dr Kaverin goes on to complain that, whatever the work schedule, *remont* "frequently drags on for half a year or more," a state of affairs that he describes as "completely intolerable."

A striking comment is also made about the duplication of diagnostic tests by hospitals and polyclinics. A Health Ministry order requires the latter to ensure that "the ambulatory medical card" is received by hospitals in respect of every referred patient but, more often than not, this order is ignored. Consequently, the investigations have to start again from the beginning, with the obvious result of increasing a patient's duration of stay.

Duration of stay alone, naturally, provides no evidence about the quality of care. From the independent vantage point of the emergency service, Dr Kaverin felt able to declare: "We know that to lie in one hospital for 40 days is far less effective than to be investigated and treated for 25 days in another."

On the basis of the second article, it must be concluded that not all the causes of overcrowding lie within the control of a hospital's head doctor. Thus he cannot easily or directly alter orders of the Health Ministry regarding compulsory admission or the pace at which *remont* takes place. Nevertheless, it is also evident that the self-righteousness of some correspondents takes no account of the scope for improvement in their own units. Although the corridor patient may be a time-honoured feature of the Soviet health service, the Botkin hospital's achievement proves that it is far from inevitable.

References

- 1 Velikanova L. "Sdelat vse vozmoznoe . . ." *Literaturnaya Gazeta* 1980; 25:11.
- 2 Kaverin N. "Skoraya pomoshch" i bolnichnaya palata. *Literaturnaya Gazeta* 1980;37:13.

What is the likely cause of blood stained discharge from the nipple in a breast that is otherwise normal?

A blood-stained discharge from the nipple is alarming and always requires very careful management on the part of the surgeon. In a study of 370 patients coming to surgery for serous, serosanguineous, or frankly blood-stained discharges, Pilnick and Leis¹ found that half were due to intraduct papillomas, 31% to fibrocystic disease, 13% to carcinoma, and 5% to advanced duct ectasia. In patients aged over 50 cancer becomes an increasingly common cause, especially if the discharge is unilateral, bloody, and emerging from a single duct. Blood-stained discharge is unilateral in most cases, but bilateral in about 8%. A glance at the nipple will immediately show whether the bleeding is from an ulcerating Paget's disease of the nipple. Both breasts are then carefully palpated. The presence of a mass, pressure on which produces the blood-stained discharge, suggests an intraduct carcinoma. In the series quoted above, however, 12% of cancer cases had no mass palpable, compared with 56.5% of intraduct papillomas. If a mass is found then excision biopsy is performed and appropriate treatment given according to whether this is a benign or malignant lesion. If a mass is not palpable the surgeon then carefully presses

around the nipple in a clockwise manner to determine if one spot produces the discharge. If so this area then requires surgical exploration, preferably through a circumareolar incision aided by a probe passed along the affected duct. If it is impossible to localise the discharge to a particular segment it is reasonable to perform a mammogram, which may disclose the lesion and allow excision biopsy to be performed. It should be remembered that a negative mammogram does not exclude neoplastic disease. Failure to localise the affected segment is an indication for keeping the patient under careful observation. In some centres cytology of the discharge is used to determine whether or not there is a malignant focus in the breast but both false-positive and false-negative reports may be obtained. The exception to urgent surgical exploration is the patient who has a serous or blood-stained discharge or a milky discharge tinged with blood and who is pregnant and near term. If no palpable mass is found it is perfectly reasonable to reassure the patient in the expectation that the discharge will clear up soon after her confinement when the vascular engorgement of the breast subsides. Only if the blood-stained discharge persists post partum need the matter be taken further.

¹ Pilnick S, Leis HP. Nipple discharge. In: Gallager HS, Leis HP, Snyderman RK, Urban JA, eds. *The breast*. St Louis: C V Mosby Co, 1978:524-31.